

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

20056

1. PLACE OF DEATH

County Merced
Township Harrison
City Camden (No.)

Registration District No. 558
Primary Registration District No. 5949

File No.
Registered No. 6
St. Ward)

2. FULL NAME

Celia Ann Brooks

(a) Residence No. St. Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widow

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

July 30 - 1883

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>47</u>	<u>10</u>	<u>12</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer) no occupation
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Harrison Co

10. NAME OF FATHER

Boon Brooks

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

Indiana

12. MAIDEN NAME OF MOTHER

Palsen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

Iowa

14. INFORMANT (Address)

Bill Brooks
Camden, Mo

15. FILED

6/23 30
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REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-14-1930

17. I HEREBY CERTIFY That I attended deceased from May 2, 1930, to June 4, 1930 that I last saw him live on May 12, 1930 and that death occurred, on the date stated above, at 5:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Organic Disease of Heart
Myocardial Insufficiency

CONTRIBUTORY (SECONDARY)

910

18. WHERE WAS DISEASE CONTRACTED

92A
95B

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

H. Nally, M.D.

1223 1930 (Address) Camden Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Goshan Cemetery June 15 1930

20. UNDERTAKER

ADDRESS

Noel Mass Princeton, Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

46-10-14

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Mercer

Registration District No. 558

File No. _____

Township Harrison

Primary Registration District No. 3749

Registered No. 6

City _____ (No. _____)

St. _____ Ward _____

2. FULL NAME

Celia Ann Brooks

(a) Residence. No. _____ St. _____ Ward _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED wid (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 30-1883

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 46 10 14 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) yrs. mos. ds.
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14.

INFORMANT _____ (Address) _____

15.

FILED 420, 30 6 E Odu

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 14 1930

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19____ (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-20056

11/11/56